PRIME RHEUMATOLOGY CLINIC OF HOUSTON PLLC
Dr. Gwendoline Menga
Phone: (832) 821-5550 Fax: (936) 207-4109

17191 St Luke's Way Suite 220
The Woodlands TX 77384

Dear Patient:

Thank you for choosing Dr. Menga for your Rheumatology care. In order to expedite the check in process, please review and complete all enclosed documents prior to your appointment. Please bring your completed forms, insurance cards, driver's license, and copies of any recent laboratory tests or imaging reports. You may, if easier for you, have them faxed to our office before your scheduled appointment.

You will receive a confirmation call from our office for each appointment the day before so please make sure to provide accurate contact information and report any changes as soon as possible. Each appointment time is scheduled for one patient in an effort to provide appropriate attention and care. Please provide our office with at least a 24-hour notice should you need to cancel or reschedule your appointment. If you miss an appointment without giving advanced notice, you will be charged up to $50 for each missed appointment.

If you have an insurance policy that requires an authorization or referral from your primary care physician, it is your responsibility to obtain one. Please make sure you have a valid referral for each visit.

Co-payment amount, if applicable, will be collected at the beginning of each visit. We accept cash, check, Visa and MasterCard. Please note that a $25 fee will be charged for any bounced or cancelled checks.

Our provider will not be able to provide care for any patient who declines to sign the Medical Services Agreement and Privacy Practices Form.

We look forward to meeting you and assisting you with your medical needs. Please contact our office should you have any further questions or concerns.

Sincerely,

Dr. Menga and staff

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OFFICE HOURS

Monday – Thursday: 8:00 am to 5:00 pm
Friday: 8:00am to 3:00pm
We are CLOSED for lunch from 12:00 pm to 1:00 pm
Phones are open from 8:00 am to 12:00pm and 1:00 pm to 5:00 pm

SCHEDULING APPOINTMENTS

Call our office during normal phone hours to make an appointment.
Any patient 15 minutes (or more) late will forfeit their appointment and will need to reschedule for a late date.
There is a $50 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTIONS

For any **new** prescriptions, please call the office with medication name, dosage, directions and your pharmacy's name and phone number.
For all refills, have the pharmacy fax over a refill request form.
For any controlled substance prescriptions, please give a 72 hour notice before the fill date.

MEDICAL RECORDS AND FORMS

All requests for medical records made by another healthcare provider will be faxed to the requesting provider free of charge.
Patient requests for medical records will incur a $25 charge.
Disability forms may be completed (at the discretion of Dr. Menga) for a fee of $25-$50.

BILLING

For all billing-related questions, please call 800-893-3557.
We accept cash, check, Visa, and MasterCard.
All copays are due at the time of service.
For self-paid patients, all balances are due at the time of service.

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MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physician, staff, or other health care providers of Prime Rheumatology clinic PLLC (PRCH) assisting my care.
2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay PRCH for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If the provider is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

I understand that my insurance policy is a contract between myself and my insurance company; PRCH is not involved. In order for PRCH to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that PRCH will need to verify my health insurance coverage. In the event that PRCH is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to PRCH for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize PRCH to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of PRCH's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize PRCH to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give PRCH any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.
4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize PRCH to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.
5. **PERSONAL VALUABLES:** PRCH shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Prime Rheumatology Clinic of Houston PLLC and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____

Signature of Patient Date or Signature of Patient's Representative & Relationship Date

_____ _____

Office Representative Signature Date

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Patient Registration

Last Name: _____ First Name: _____MI: _____
DOB: _____ Social Security #: _____
Address: _____City: _____State: _____ Zip: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Driver's License Number: _____ Issuing State: _____
Employer:_____ Occupation: _____
Email Address: _____

Emergency Contacts:
1. Name: _____ Relationship: _____ Phone Number: _____
2. Name: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Who referred you to Prime Rheumatology Clinic? _____

Primary Insurance Coverage:
Company: _____ Effective Date: _____ Group Number: _____
Policy Number: _____ Phone Number: _____

Secondary Insurance Coverage:
Company: _____ Effective Date: _____ Group Number:_____
Policy Number: _____ Phone Number:_____

If you are covered under the policy of a spouse, partner, parent or legal guardian, please complete the following information:
Last Name: _____ First Name: _____ MI:_____
DOB: _____ Social Security #:_____
Address: _____ City: State: _____ Zip: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Employer: _____ Occupation: _____

Assignment of Insurance Benefits and Authorizations for Release of Information.

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Prime Rheumatology clinic PLLC for any services furnished to me. I authorize any holder of medical information needed to release to the Health Care Financing Administration, its agents and/or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

_____

Signature of Patient **Date**

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RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? _____

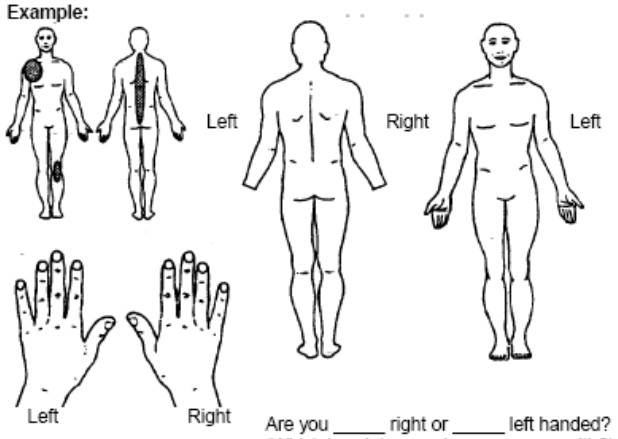
Name of your primary care physician: _____

Describe briefly your present symptoms: _____

When did your symptoms start? _____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

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RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	
Osteoarthritis	❑	❑	→	
Rheumatoid arthritis	❑	❑	→	
Gout	❑	❑	→	
Lupus or "SLE"	❑	❑	→	
Ankylosing spondylitis	❑	❑	→	
Childhood arthritis	❑	❑	→	
Sjogren's syndrome	❑	❑	→	
Osteoporosis	❑	❑	→	
Psoriasis/psoriatic arthritis	❑	❑	→	

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): _____

Previous Operations

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

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Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?_____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

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SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

GENERAL
❑ Recent weight gain; how much____
❑ Recent weight loss: how much____
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Morning stiffness
Lasting how long ____ Minutes
____ Hours
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
List joints affected in the last 6 months

_____
_____
_____
_____

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Feels like something in eye

MOUTH
❑ Sore tongue
❑ Bleeding gums
❑ Sores in mouth
❑Loss of taste
❑ Dryness
❑ Recent increase in tooth cavities

NOSE
❑ Nosebleeds
❑ Loss of smell

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw while chewing

NECK
❑ Swollen glands
❑ Tender glands

HEART AND LUNGS
❑ Pain in chest
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Swollen legs or feet
❑ Cough
❑ Coughing of blood
❑ Wheezing

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain relieved by food
❑ Vomiting of blood/"coffee grounds"
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

KIDNEY/URINE/BLADDER
❑ Difficult urination
❑ Pain or burning on urination
❑ Blood in urine
❑ Cloudy, "smoky" urine
❑ Pus in urine
❑ Discharge from penis/vagina
❑ Frequent urination
❑ Getting up at night to pass urine
❑ Vaginal dryness
❑ Rash/ulcers
❑ Sexual difficulties
❑ Prostate trouble

BLOOD
❑ Anemia
❑ Bleeding tendency

SKIN
❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Sun sensitive
❑ Skin tightness
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
❑ Headaches
❑ Dizziness
❑ Fainting or loss of consciousness
❑ Numbness or tingling in hands/feet
❑ Memory loss
❑ Muscle weakness

PSYCHIATRIC
❑ Depression
❑ Excessive worries
❑ Difficulty falling asleep
❑ Difficulty staying asleep

For women only:
Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _____

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Authorization for Disclosure of Confidential information

Patient Name: _____

DOB: _____

Address:_____

I,_____ authorize the release of my protected health information including results of my laboratory tests, X-rays and /or other test results to the following designated representative(s)

Patient Initials

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Others (Name) _____

_____ May be left on my answering machine at home

_____ May be left on my answering machine at work

_____ May be left on my cell phone at: _____

_____ **May not be given to anyone other than myself**

_____
(Date) (Signature of Participant)

_____
(Date) (Witness)

This authorization shall be valid for one year from the date of signature above unless revoked in writing by the patient prior to that expiration. As a patient, you have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. In order for revocation of this authorization to be effective, Prime Rheumatology Clinic of Houston must receive the revocation in writing. The Revocation must include 1) the patient's name, address, and date of birth. 2) Patient's desire to revoke the authorization. 3) Date of revocation and the patient signature. All revocation must be sent in writing to the attention Prime Rheumatology Clinic's Privacy officer at 17191 St Luke's Way #220, The Woodlands, TX 77384. Phone: (832) 821-5550 and Fax: (936) 207 4109

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Patient Electronic Communication Consent

Prime Rheumatology clinic is dedicated to keeping your medical record information confidential. To better serve our patients, out office has established a patient portal for some forms of electronic communication. Despite our best efforts, due to the nature of the patient portal and email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email and internet usage corporate property and your messages and internet usage may be monitored. Even when emailing from home, you may feel that access to your email and internet usage is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your physician, the staff and/or colleagues would have access to this information.

When sending mail, please put the subject of your message so we can process it more efficiently. Also, include your name and return telephone number in the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above electronic communication policy.

By signing below, I are agreeing that Prime Rheumatology Clinic may send medical related correspondence to me via electronic communication, and that we may respond to your electronic communication to us via electronic communication.

_____ _____

Patient Signature Witness (optional)

_____ _____

Patient Name Date of Birth

_____

Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Prime Rheumatology Clinic of Houston (PRCH) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Prime Rheumatology Clinic of Houston, PLLC (PRCH) please contact us at (832) 821-5550, or 17191 St Luke's Way, The Woodlands, TX 77384

I. How PRCH may Use or Disclose Your Health Information: PRCH collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of PRCH, but the information in the medical record belongs to you. PRCH protects the privacy of your health information. The law permits PRCH to use or disclose your health information for the following purposes:

1. Treatment. We may disclose your health care information to other healthcare professionals for the purpose of treatment, Payment or healthcare operations. Example*: Reviews of your file by a doctor whom we may involve in your care.*
2. Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Example: *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Prime Rheumatology Clinic of Houston, PLLC for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you for your insurance company for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received"*
3. Regular Health Care Operations. We may disclose your health information to a staff member in order that they may process paperwork, input computer information, fill out report forms, for copying or faxing whereby your medical condition, diagnosis and treatment may be visible to them in their day to day work. "*If a staff member is asked to copy records that are to be sent to another doctor at your request."*
4. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
5. Required by law. As required by law, we may use and disclose your health information.
6. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
7. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
8. Law enforcement/Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
9. Deceased person information/ Organ donation. We may disclose your health information to coroners, medical examiners and funeral directors. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
10. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
11. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

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13. Reminders. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
14. Charitable Causes. We may contact you to participate in fund-raising activities for blood drives, food bank raising donations or other charitable entities that we may be involved with to benefit those in need.
15. Change of Ownership. In the event that PRCH is sold or merged with another organization, your health information/record will become the property of the new owner.
16. Emergencies. We may disclose your health information, to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

II. Prime Rheumatology Clinic of Houston, PLLC May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, PRCH will not use or disclose your health information without your written authorization. If you do authorize PRCH to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. PRCH is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location
3. You have the right to inspect and copy your health information.
4. You have a right to request that PRCH amend your health information that is incorrect or incomplete. PRCH is not required to change your health information and will provide you with information about PRCH denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by PRCH, except that PRCH does not have to account for the disclosures described in parts (treatment), (payment), (health care operations), (information provided to you), (directory listings) and (certain government functions) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please circle the areas of concern and give to the front desk receptionist for follow up.

Changes to this Notice of Privacy Practices

PRCH reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, PRCH is required by law to comply with this Notice. Revised notices will be posted in the office and given to each new patient as they come in for care.

Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to U.S. Department of Health and Human Services (DHHS); we will provide you with the address to file your compliant. We will not retaliate in any way if you choose to file a complaint.

**These privacy practices are currently in effect and will remain in effect until further notice.*

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES NOTICE

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES provided by Prime Rheumatology clinic governed by the Health Insurance Portability and Accountability Act (HIPAA).

Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices Notice, but could not obtain it for the following reason:

____ 1. Individual refused to sign.
____ 2. Communication barriers prohibited acknowledgement.
____ 3. An emergency situation prevented us from obtaining acknowledgement.
____ 4. Other (please specify): _____

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Medical Record Request Form

Requesting information on the following patient:

Patient Name: _____ DOB: _____

REQUESTING PHYSICIAN: Dr. Gwendoline Menga

AUTHORIZING RECORDS TO BE RELEASED FROM:

Physician First & Last Name: _____

Address: _____

Phone Number: _____ Fax: _____

I hereby authorize the release of all medical records in your possession regarding my illness/treatment as indicated to the requesting physician. I understand that the disclosed information may be subject to re-disclosure by the recipient. Please forward all records to:

Prime Rheumatology Clinic of Houston PLLC

RECORDS REQUESTED: Please send only the most recent unless otherwise specified.

____ Progress Notes
____ X-ray
____ MRI
____ EKG
____ Infusion Report
____ Labs
____ DEXA
____ CT scan
____ EMG/NCS
____ Other

Purpose of Disclosure:

__ Medical Care __ Insurance __ Attorney __ Other (specify) _____

Patient Signature: _____ Date: _____

(This authorization is valid for 180 days from signed date and may be revoked in writing at any time)

PRIME RHEUMATOLOGY CLINIC OF HOUSTON PLLC
Dr. Gwendoline Menga
Phone: (832) 821-5550 Fax: (936) 207-4109

17191 St Luke's Way Suite 220
The Woodlands TX 77384

Pharmacy Information

Dear Patient

In an effort to better serve you, Prime Rheumatology Clinic of Houston now have the capability of sending your prescriptions directly to your pharmacy electronically.

Please provide the following information:

( ) NO CHANGE IN PHARMACY INFORMATION SINCE MY LAST VISIT

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Street Address: _____

City: _____

Zip Code: _____

Pharmacy Phone Number: _____